*Information Summary and Recommendations*

# MASTECTOMY SERVICES
# Mandated Benefits Sunrise Review

December 1997

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# MASTECTOMY SERVICES
# Mandated Benefits Sunrise Review

## *Executive Summary and Recommendations*

# EXECUTIVE SUMMARY

## PROPOSAL FOR SUNRISE REVIEW

Senate Bill 5297 requires that only the attending physician, in consultation with the patient, may make a decision concerning length of stay for mastectomy services. Health plans may not take retaliatory action against a physician for his/her length of stay decisions. No specific length of stay minimum is provided.

## THE SUNRISE REVIEW PROCESS

In spring 1997, Senator Alex Deccio, chair of the Senate Health and Long Term Care Committee, requested the Department of Health to review SB 5297 under provisions of RCW 48.42.080. This statute requires the department to make recommendations to the legislature on bills proposing new mandated health benefits, using criteria specified in the statute, when the legislature requests such reviews and funds are made available for the purpose. A "mandated health benefit" is a coverage provision that must be present in all health insurance sold in the state. The criteria for these "sunrise reviews" deal with social impact, financial impact and the effectiveness of the benefits mandated.

Further information on mandated benefits and the sunrise review process is contained in Appendix B. Because SB 5297 is an atypical mandated benefit bill--it focuses on decision-making about how to conduct a procedure, mastectomy, which is already covered by most health insurance policies--special care was taken at early stages of the sunrise review to clarify questions which should be addressed.

## BACKGROUND ON MASTECTOMY

There is no state regulation that specifically mandates how long a patient must remain in the hospital for a given mastectomy procedure (or any other medical procedure) or even that a person must be treated on an inpatient basis. Current trends, as described by health plans, patient testimony, and data reported to the department, are toward shorter length-of-stay and toward outpatient procedures for simpler mastectomy operations.

As with any surgery, the appropriate length of stay depends on the practice patterns of the physician, the medical needs and condition of the patient, and the type of surgery involved.

# RECOMMENDATIONS

1. SB 5297, Mastectomy Services, should not be passed as written.

Rationale:

(a) Shorter lengths of stay for surgeries can be attributed to many factors, including newer procedures, methods of post-surgery recovery, better anesthesia, the need to eliminate unnecessary health care costs, and a desire to avoid nosocomial infections.

(b) While there was limited testimony that physicians were pressured by health plans or hospitals for early discharge of mastectomy patients, it was not clearly documented that negative outcomes have resulted from shorter lengths of stay, or were likely to in the foreseeable future.

(c) Financial and social impact of the bill is likely to be minimal because most length of stay decisions about mastectomy already are being made by physicians and patients. However, the criteria favor rejecting a mandated benefit unless there is a clear social and/or health benefit which outweighs any costs.

(d) Any remedy to possible problems with health plans or hospitals imposing medically inappropriate requirements on physicians should be handled through a combination of broad oversight structures and non-regulatory guidelines (see also Recommendation 3). Existing oversight tools include carrier regulation under the state Insurance Code, professional regulation (including the Medical Quality Assurance Commission), and the requirements of the National Committee on Quality Assurance and similar accreditation organizations which many health plans must meet due to the demands of major health care purchasers. If additional regulation is necessary, it should be designed to address similar problems regardless of the diagnosis or procedure.

(e) It is possible that an unintended consequence of the wording is to move more mastectomies to an outpatient basis as they are not covered in the provisions of the bill.

(f) Rather than focus on the length of stay, the focus of any interventions should be around developing standards for the type of pre- and post-operative services that are necessary to ensure a positive physical and emotional recovery from mastectomy.

2. If the bill is passed, the following technical improvements should be made. First, a definition of "mastectomy" should be added in Section

2, paragraph 1, and Section 3, paragraph 1. The definition should cover the procedures unilateral simple, bilateral simple, unilateral extended simple, unilateral extended with unilateral simple, bilateral extended simple, and unilateral radical, as well as lumpectomy. Second, the language of sections 2 (2) (a) and 3 (2) (a) should be extended to include outpatient mastectomy, as follows: "Every health carrier that provides coverage for mastectomies must permit the attending provider, in consultation with the patient, to make decisions on the site of surgery (inpatient or outpatient) and, if inpatient, the length of stay." These changes would not alter the department's recommendation against passage, but they would clarify issues of public concern.

3. Interested parties should work together to help define appropriate standards of care, and ways to encourage their use, and find mechanisms to revise those standards as technology and medical practice advance, or as abuses or problems are uncovered.

Rationale:

(a) Medical standards work better when developed and implemented by those directly involved.

(b) Of the thousands of clinical guidelines in existence, many are influential but few are regulatory. A system that is too rigid cannot adapt to changing science and technology, or to changes in health system financing and delivery that may affect the state's interest in how care is delivered.

4. The legislature should seriously consider the department's efforts to develop a feasible ambulatory patient data system. This will help to monitor outpatient surgery outcomes.

Rationale:

(a) The lack of outpatient data makes it more difficult to know the results of outpatient mastectomies affect outcomes.

(b) Data does show that more procedures -- for mastectomies and other surgeries -- are moving more to an outpatient basis. Science-based public policy making requires the on going collection of a complete set of data. The current system lacks key components for decision making, which an ambulatory patient data system would provide.

5. The legislature should reconsider the department's 1996 proposal to regulate ambulatory surgical centers.

   (a) Regulation of ambulatory surgical centers would allow the state to monitor performance for all types of surgeries.

## SOURCES OF INFORMATION

No "applicant group" came forward during this review to provide a written report addressing the statutory criteria, as envisioned by RCW 48.42. The department relied on information from a literature review, testimony by interested persons, and analysis of available Washington state data. The Health Care Authority estimated no impact on state expenditures.

The body of this report identifies specific findings based on this information, and relates the findings to the statutory criteria. The information from various sources also is summarized in the report and appendices.

Several potentially relevant surveys are in progress in Washington State, but their sponsors did not provide the department with results or with information documenting whether they are being conducted in a manner likely to produce scientifically valid results.

# MASTECTOMY SERVICES
# Mandated Benefits Sunrise Review

*Information Summary*

# CURRENT REGULATION AND PRACTICE OF MASTECTOMY

Mastectomy procedures -- which range from segmental removal (lumpectomy) to bilateral breast and lymph node removal -- have shown a shift from an inpatient to outpatient basis. Although indications are that overall breast cancer rates have not declined, data reported by hospitals to the Department of Health indicate a decline in the number of inpatient mastectomy procedures. There could be several reasons for this, which will be discussed later in this report.

There is no state regulation that specifically mandates how long a patient must remain in the hospital for a given mastectomy procedure (or any other medical procedure) or even that a person must be treated on an inpatient basis. Current practice, as described by health plans, patient testimony, and data reported to the Department, is for a shorter length-of-stay per inpatient procedure and a move to outpatient procedures for simpler mastectomy operations.

Medicare policies forbid limits on hospital stays for mastectomies, and the member organizations of the managed care group American Association of Health Plans have agreed with a similar policy, that also includes prohibitions on plans requiring outpatient mastectomies.

There are efforts in Congress, as well as in many individual states, to enact a 48 hour minimum length-of-stay for mastectomies. In 1997, 36 states introduced over 130 bills on mastectomies, the majority addressing length of stay. Arkansas, Connecticut, Illinois, Maine, Texas, Rhode Island, New York, Florida, Montana, New Mexico, Oklahoma, and New Jersey have enacted legislation. Most require a minimum length of stay , or prohibit plans from limiting stays. (NCSL 1997; State Cancer Legislative Database Update, National Cancer Institute, July 1997).

As with any surgery, the appropriate length of stay depends on the practice patterns of the physician, the medical needs and condition of the patient, and the type of surgery involved. The shift to shorter lengths-of-stay and outpatient treatment for mastectomies seems to be consistent with length-of-stay and outpatient practices for other surgeries. (See Appendix H and I). An organization called "MediQual" listed dozens of DRG (Diagnosis Related Group) and the average length of stay from 1993/94 to 1995/96. Two hundred one DRGs saw decreases, ranging from -1% to -55%. There were 4 DRGs with no change, and 30 with increased length of stay, ranging from 1% to 42%. Some of those with major declines were fractures of hip, femur or pelvis, cardiac arrest, splenectomy, major limb operations, cleft palate operations, and eye disorders.

Length of Stay data for a variety of mastectomy procedures are reported in Appendix H and I. Using Cancer Registry data and hospital reporting data, estimates of the numbers of outpatient versus inpatient mastectomy (and related) procedures can be given. The department estimates that in 1995 more than 60% of all surgeries for breast cancer were performed on an outpatient basis. (Appendix D).

Currently there is no state regulation of ambulatory surgery centers where outpatient procedures are performed. There are no reporting requirements to indicate surgical outcomes. Therefore, there is no data available to evaluate quality of care in a large number of mastectomy procedures. Outpatient procedures performed in hospital settings or in facilities owned and operated by hospitals could be monitored by those responsible for hospital quality (including JCAHO). Individual physicians performing surgeries and those who are responsible for overall care of mastectomy patients are regulated by the Medical Quality Assurance Commission and could be subjected to discipline by the commission for substandard care.

## PROPOSAL FOR SUNRISE REVIEW

Senate Bill 5297 requires that only the attending physician, in consultation with the patient, may make a decision concerning length of stay for mastectomy services. Health plans may not take retaliatory action against a physician for his/her length of stay decisions. No specific length of stay minimum is provided.

There is no definition of "mastectomy" and there is no provision covering outpatient procedures.

There are no specific penalties cited for failure to comply; however, the Insurance Commissioner has broad authority for enforcing RCW 48.43, which would be amended by this legislation.

## FINDINGS

*(Note: for purposes of discussion in this section "mastectomy" includes all related procedures, including "lumpectomies", "unilateral simple" and "bilateral extended simple." Definitions of all procedures are included in the tables that constitute Appendix H and I.)*

Trends in Mastectomy

1. Based on data developed by the Department of Health and other reports, lengths of stay for all surgical procedures, and for all payer groups, have been declining over the past eight years. The average length of stay for

mastectomies (not including lumpectomy) has declined by 25%, which is within the range for selected other surgeries (declines of between 17% and 33% ).

2. Based on data developed by the Department of Health, in Washington state, from 1992 to 1995, the number of new cases of breast cancer rose, while the number of inpatient surgeries declined by about 25%. (See Appendix D) In some cases, treatment options other than surgery may have been selected by the patient. Nevertheless, some of the decline can be attributed to moving from inpatient to outpatient surgery.

3. Testimony and scientific literature indicate that advances in surgical and treatment techniques, patient preference, cost containment, and a desire to lessen patient exposure to nosocomial infections have all played a part in the reduction in mastectomy length of stays and a move to outpatient procedures.

Social Impact of the Proposal

4. Based on testimony and articles critical of the reduction in mastectomy lengths-of-stay, proponents of SB 5297 believe it will provide three social benefits. First, they believe it will improve the quality of care by reducing the probability of *inappropriately* short lengths-of-stays. Second, they believe it will alleviate *fear* that this will happen Third, they believe the legislation will increase women's *involvement* and sense of control in decisions about their treatment for breast cancer, which in turn is believed to aid recovery and counter fear.

5. No evidence was presented or discovered by the department which would indicate a pattern of bad clinical outcomes in Washington associated with shorter lengths of stay. Hospitalization data were examined to see if there was an increase in readmissions within 14 days of mastectomy surgery, as the length of stay declined, but no such pattern was found; readmissions stayed constant at about 5%.

6. While some patients and physicians believe that outpatient mastectomies are ill-advised and inappropriate in most cases, no formal studies were presented to counter the fact that there are clinical and controlled scientific studies documenting outpatient mastectomy programs which achieve good outcomes.

7. Testimony and literature noted that a reduction in length of stay or shift to outpatient procedures should only occur when accompanied by improved presurgical consultation and patient preparation as well as post surgical care. This post surgical care does not have to be on an inpatient

basis. The department was not able to obtain any information to indicate this was or was not the uniform current practice.

8. Based on testimony, most length of stay decisions are made currently by physicians and patients. Some advocates of this legislation note that this is a pre-emptive strike against potential problems. Hospitals may be a factor in determining the length of stay or whether a procedure is performed on outpatient versus inpatient basis for a patient. (Hospitals are not mentioned in the proposed legislation.)

9. There is limited, anecdotal evidence that some mastectomy patients are being discharged from hospitals before they want to, due to pressure (real or perceived) from health plans or hospitals. It is likely that similar reports could be gathered for other surgical procedures, based on overall reductions in length of stay. Discharge of surgical patients should be consistent with a level and type of care medically appropriate for each patient. There was general consensus that this currently was the overall approach used by most health plans, hospitals and physicians for mastectomy patients.

10. Because current principles and practices of most insurers and health plans are consistent with the requirements of SB 5297, the department does not expect that its enactment would significantly improve the health status of mastectomy patients or increase patients' participation in care decisions. It might alleviate fear, but there is no evidence on this point.

Financial Impact of the Proposal

11. There is evidence that shorter inpatient length of stay can reduce medical costs for mastectomy depending on the type of payment structure involved. However, there is no evidence about whether SB 5297 would change current trends, so no direct financial impact can be assumed. No studies addressing non-medical costs were identified.

12. COST-BENEFIT DISCUSSION. As noted, current principles and practices of most insurers and health plans are consistent with SB 5297 Therefore, the department does not expect that its enactment would changes health insurance costs, affect the overall cost of health care, or (finding 10) improve the health status of mastectomy patients. Based on this expectation, cost-benefit analysis neither supports or undermines the proposed legislation.

13. The legislation may have the unintended effect of providing an incentive to perform more of these procedures in unregulated ambulatory surgery centers (ASCs). Such a change would lower costs (procedures performed

in ASCs are generally less expensive then comparable procedures at hospitals) and have an undetermined effect on patient health status. A cost-benefit analysis to assess the likelihood and consequences of this unintended effect was beyond the scope of this review.

Efficacy of the Mandated Change

14. The "mandate" in SB 5297 deals with leaving length-of-stay decisions in the hands of providers and patients. There was some public testimony and some scientific literature to support the idea that active patient participation in treatment decisions can have a positive impact on a person's overall health status. However, there is no evidence of the actual impact of regulatory requirements such as SB 5297 on the degree to which such participation or the resulting quality of care.

# DISCUSSION OF AVAILABLE INFORMATION

This concluding section of the report reviews available information in greater depth. It is offered in support of the findings above, and the report's recommendations which, along with rationales, are found in the Executive Summary.

## Applicant Group Report

No "applicant group" came forward during this review to provide a written report addressing the statutory criteria, as envisioned by RCW 48.42.

## Literature Review

Many scientific journal articles reviewed reasons for and benefits from shorter lengths of stay for a variety of surgical procedures, including mastectomies. Case studies often followed the treatment of patients who had volunteered for outpatient mastectomies. Some articles discussed the types of pre- and post-operative care that allow outpatient procedures to be used. Results of studies on shorter-than-previous lengths of stay for mastectomies and other surgical procedures tended to show no increase in negative outcomes and increased patient satisfaction.

Several professional organizations and the federal government have issued guidelines on length of stay and/or the use of outpatient mastectomies. The American Cancer Society notes that types of situations in which outpatient procedures are appropriate. The American Association of Health Plans and the federal government have guidelines that prohibit a health plan from requiring the use of outpatient mastectomies.

Other articles, mostly in the news media, cite public concern over the trend to shorter lengths of stay and outpatient procedures.

The full discussion of the literature reviewed by the department is Appendix L.

## Surveys in Progress

Several potentially relevant surveys are in progress or completed but unreleased in Washington State: However, the sponsors of the surveys did not provide the department with results or with information documenting whether they are being conducted in a manner likely to produce scientifically valid results.

## Public Testimony

*Although no "Applicant Group" came forward during this process to provide a written report as envisioned by RCW 48.42, several cancer patients, some providers and some insurers participated in one or both public meetings held by the department.*

Public testimony emphasized the benefits of and need for patient choice in decision making surrounding length of stay. Dr. Alison Longley noted that SB 5297 recognizes "patient preference and the clinical sovereignty of providers," and that this concept merits support. Breast cancer patients face many fears and challenges, and being told that she needs to leave the hospital the same day makes the situation worse.

Dr. Cathleen Carr noted that "there is a lot of fear involved with cancer, and this fear contributes to apprehension about treatment and possible interference by health plans in that treatment."

Two health plans participated, and noted generally that what is proposed in SB5297 is current practice -- that surgeons and patients select pre- and post-operative care, as well as the type of inpatient care.

One physician wrote to the department, "I have found that a patient who understands her disease and can be involved in the decision making is more likely to have a good outcome and less disruption to her life." He emphasized that while nobody wants to stay in the hospital longer than necessary, "there is the need to have the ability to stay in as long as their practitioner deems appropriate."

The full text of testimony provided during the review appears as Appendix N.

## Analysis of Department of Health Data: Summary

*(Note: these data are detailed in Appendix D, E, H, I, J and K)*
*A more detailed discussion of the analysis appears as Appendix M.*

The department maintains a hospital discharge data set (CHARS) that captures information on inpatient hospitalizations, including reason for hospitalization, procedures and length of stay (LOS). From this data set, the department developed information on changes in LOS for mastectomies and other procedures in the 1990s. The department also maintains the Washington State Cancer Registry (WSCR), which provides information about the type of cancer and treatment for each patient. This data set provided information on overall incidence of breast cancer from 1992-1995. Combining information from WSCR and CHARS allowed the department to develop estimates of the proportion of mastectomies conducted on an outpatient basis.

In Washington state, the number of new cases of diagnosed breast cancer has increased from approximately 3800 in 1992 to 4200 in 1995. In 1995, 46% of new cases were in women ages 65 years and older. In the same year, 46% of all in-patient mastectomy surgeries in Washington state were on patients age 65 or older.

For mastectomies, (not including lumpectomies) the average LOS decreased from 2.7 days to 2.0 days from 1990 to 1996.

In 1996, Washington HMO patients had an average LOS of 1.8 days, other non-government insurance clients had 1.9 days, and Medicare patients had 2.0 days. HMOs had 51% of patients with a LOS of less than 2 days; other non-government insurance had 44% of patients with LOS of less than 2 days; and Medicare had 40% in that category.

In Washington state, the number of inpatient procedures has fallen, with breast cancer cases diagnosed being relatively steady, suggesting an increase in outpatient surgeries. Estimates of proportion of inpatient surgeries were developed by combining CHARS and WSCR data supports this conclusion. The department estimates that 60% of breast cancer surgeries were performed on an inpatient basis in 1992. For 1995, the estimate for the percent of inpatient surgeries for mastectomy had dropped to about 38%.

Hospital readmission data for 1995 shows that of all patients admitted for mastectomy procedures (lumpectomy excluded), 3% were readmitted within 7 days and 5% were readmitted within 14 days. It is not known whether these readmissions were for complications of the mastectomy surgery. The

percentage of readmissions remains fairly constant from 1990 to 1996, despite a decrease in average LOS of 25%, and an increase in the percentage of patients staying less than 2 days from 11% to 44%. This is also fairly constant across age groups and by type of payer.

# REBUTTAL STATEMENTS

## REVIEW PANEL

Juliet van Eenwyck, Director of Non-Infectious Conditions Epidemiology Office of Epidemiology, Department of Health

Linda Johnson, Immunization Program Manager, Community and Family Health, Department of Health

Steve Boruchowitz, Senior Health Policy Analyst, Health Systems Quality Assurance, Department of Health

# APPENDIX A

# SENATE BILL 5297

S-0542.1

# SENATE BILL 5297

**State of Washington 55th Legislature 1997 Regular Session**

**By** Senators Franklin, Winsley, Kohl, Patterson, Thibaudeau, Goings, Fraser, Heavey, Snyder, Loveland, Prentice, McAuliffe, Spanel, Rasmussen, Wojahn, Fairley, Sheldon, Wood, Brown and Haugen

Read first time 01/22/97. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to health insurance benefits for mastectomies; adding a new section to chapter 48.43 RCW; adding a new section to chapter 41.05 RCW; and creating a new section.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The legislature recognizes the role of health care providers as the appropriate authority to determine and establish the delivery of quality health care services to mastectomy patients. It is the intent of the legislature to recognize patient preference and the clinical sovereignty of providers as they make determinations regarding the length of time individual patients may need to remain in a health care facility after mastectomies. It is not the intent of the legislature to diminish a carrier's ability to utilize managed care strategies but to ensure the clinical judgment of the provider is not undermined by restrictive carrier contracts or utilization review criteria that fail to recognize individual needs.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Unless otherwise specifically provided, the following definitions apply throughout this section:

(a) "Attending provider" means a provider who: Has clinical hospital privileges consistent with RCW 70.43.020; is included in a provider network of the carrier that is providing coverage; and is a physician licensed under chapter 18.57 or 18.71 RCW.

(b) "Health carrier" or "carrier" means disability insurers regulated under chapter 48.20 or 48.21 RCW, health care services contractors regulated under chapter 48.44 RCW, health maintenance organizations regulated under chapter 48.46 RCW, plans operating under the health care authority under chapter 41.05 RCW, the state health insurance pool operating under chapter 48.41 RCW, and insuring entities regulated under this chapter.

(2)(a) Every health carrier that provides coverage for mastectomies must permit the attending provider, in consultation with the patient, to make decisions on the length of inpatient stay, rather than making such decisions through contracts or agreements between providers, hospitals, and insurers. These decisions must be based on accepted medical practice.

(b) Nothing in this section shall be construed to require attending providers to authorize care they believe to be medically unnecessary.

(3) No carrier that provides coverage for mastectomies may deselect, terminate the services of, require additional documentation from, require additional utilization review of, reduce payments to, or otherwise provide financial disincentives to any attending provider or health care facility solely as a result of the attending provider or health care facility ordering care consistent with the provisions of this section. Nothing in this section shall be construed to prevent any insurer from reimbursing an attending provider or health care facility on a capitated, case rate, or other financial incentive basis.

(4) Every carrier that provides coverage for mastectomies must provide notice to policyholders regarding the coverage required under this section. The notice must be in writing and must be transmitted at the earliest of the next mailing to the policyholder, the yearly summary of benefits sent to the policyholder, or January 1 of the year following the effective date of this section.

(5) This section is not intended to establish a standard of medical care.

(6) This section applies to coverage for mastectomies under a contract issued or renewed by a health carrier after the effective date of this section.

NEW SECTION. **Sec. 3.** A new section is added to chapter 41.05 RCW to read as follows:

(1) For the purposes of this section, "attending provider" means a provider who: Has clinical hospital privileges consistent with RCW 70.43.020; is included in a provider network of the carrier that is providing coverage; and is a physician licensed under chapter 18.57 or 18.71 RCW.

(2)(a) Every state purchased health care plan that provides coverage for mastectomies must permit the attending provider, in consultation with the patient, to make decisions on the length of inpatient stay, rather than making such decisions through contracts or agreements between providers, hospitals, and insurers. These decisions must be based on accepted medical practice.

(b) Nothing in this section shall be construed to require attending providers to authorize care they believe to be medically unnecessary.

(3) No state purchased health care plan that provides coverage for mastectomies may deselect, terminate the services of, require additional documentation from, require additional utilization review of, reduce payments to, or otherwise provide financial disincentives to any attending provider or health care facility solely as a result of the attending provider or health care facility ordering care consistent with the provisions of this section. Nothing in this section shall be construed to prevent any insurer from reimbursing an attending provider or health care facility on a capitated, case rate, or other financial incentive basis.

(4) Every state purchased health care plan that provides coverage for mastectomies must provide notice to policyholders regarding the coverage required under this section. The notice must be in writing and must be transmitted at the earliest of the next mailing to the policyholder, the yearly summary of benefits sent to the policyholder, or January 1 of the year following the effective date of this section.

(5) This section is not intended to establish a standard of medical care.

(6) This section applies to coverage for mastectomies under a contract issued or renewed by a state purchased health care plan after the effective date of this section.

--- END ---

# APPENDIX B

# SUNRISE REVIEW PROCESS AND REVIEW CRITERIA

## Mandated Health Benefits Sunrise Review Process

A "mandated health benefit" is a coverage provision that must be present in all health insurance sold because of requirements of state law. Mandated benefits are usually specific health care services, supplies or equipment that must be covered, or requirements to cover the services of a particular kind of health care provider. However, specific mandated benefit provisions or legislative proposals may vary quite a bit. Some actually are requirements for insurance carriers to *offer* the benefit to any group or individual who buys a policy. Some apply to state-purchased health care (such as Medicaid and the Basic Health Plan) as well as to privately purchased insurance. State legislatures cannot mandate that benefits apply to health coverage that is directly provided by employers (rather than arranged by the employers through purchase of insurance), due to the effect of a federal law that preempts state regulation in this area.

Washington state statute requires that proponents of new mandated health insurance benefits must provide specific information to the legislature. Should the legislature request, and if funds are made available, the Department of Health makes recommendations to the legislature on the proposals, using criteria specific in the statute. The criteria for these "sunrise reviews" deal with social impact, financial impact and the effectiveness of the benefits mandated. The criteria are contained in RCW 48.42.080 and in this Appendix.

The legislature's intent is that all mandated benefits show a favorable cost-benefit relationship and that they not unreasonably affect the cost and availability of health insurance. In addition, the statute states (in RCW 48.42.060) that "the cost ramifications of expanding health coverages is of continuing concern and that the merits of a particular mandated benefit must be balanced against a variety of consequences which may go far beyond the immediate impact upon the cost of insurance coverage."

### The Review Process

Formal notification is provided to the applicant group and other interested parties that the legislature has requested the department to review a mandated benefits proposal, indicating that the review process has begun.The sunrise process formally begins about three weeks later with a public meeting intended to "scope out" key issues (as well as non-relevant issues); pose questions from the review panel to the applicant (both technical and policy); review sunrise criteria and process with participants; and identify key players who might be absent from the meeting. The

applicant is requested to bring a summary of the proposed benefit and answers to the specified questions.

The department gathers information from various sources, and conducts an analysis. The Health Care Authority provides cost analysis based on the information provided and any other information the Authority may have access to. A cost-benefit analysis is conducted to the extent possible given the information provided to the department.

A draft of the department's final report, including findings and recommendations, is distributed as soon as possible after the public hearing. The report is forwarded through the Governor's office to the legislature.

# Mandated Benefits Sunrise Reviews
## Statutory Review Criteria
(From RCW 48.42.080)

Based on the availability of relevant information, the following criteria shall be used to assess the impact of proposed mandated benefits:

1. The Social Impact:

   (i) To what extent is the benefit generally utilized by a significant portion of the population?

   (ii) To what extent is the benefit already generally available?

   (iii) If the benefit is not generally available, to what extent has its unavailability resulted in persons not receiving needed services?

   (iv) If the benefit is not generally available, to what extent has its unavailability resulted in unreasonable financial hardship?

   (v) What is the level of public demand for the benefit?

   (vi) What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this benefit in group contracts?

2. The financial impact:

   (i) To what extent will the benefit increase or decrease the cost of treatment of service?

   (ii) To what extent will the coverage increase the appropriate use of the benefit?

   (iii) To what extent will the benefit be a substitute for a more expensive benefit?

   (iv) To what extent will the benefit increase or decrease the administrative expenses of health carriers and the premium and administrative expenses of policyholders?

   (v) What will be the impact of this benefit on the total cost of health care services and on premiums for health coverage?

   (vi) What will be the impact of this benefit on costs for state-purchased health care?

(vii) What will be the impact of this benefit on affordability and access to coverage?

3. Evidence of health care service efficacy:

(i) If a mandatory benefit of a specific service is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the health consequences of that service compared to no service or an alternative service?

(ii) If a mandated benefit of a category of health care provider is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the health consequences achieved by the mandated benefit of this category of health care provider?

(iii) To what extent will the mandated benefit enhance the general health status of the state residents?

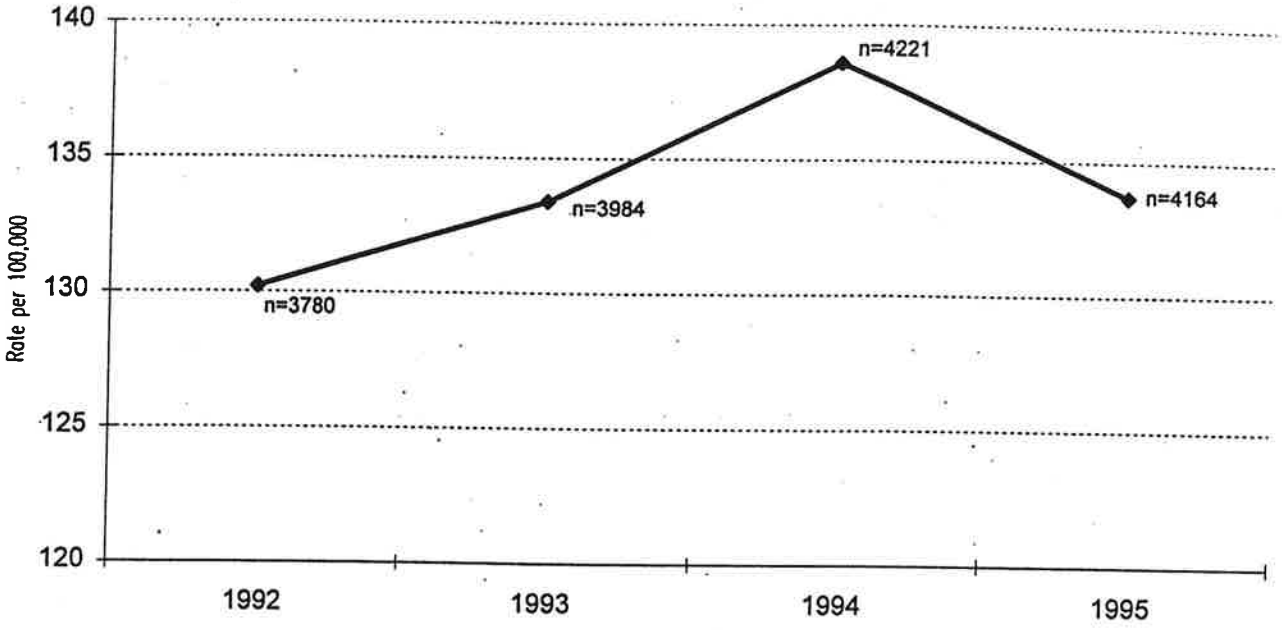
The department may supplement these criteria to reflect new relevant information or additional significant issues.

# APPENDIX C

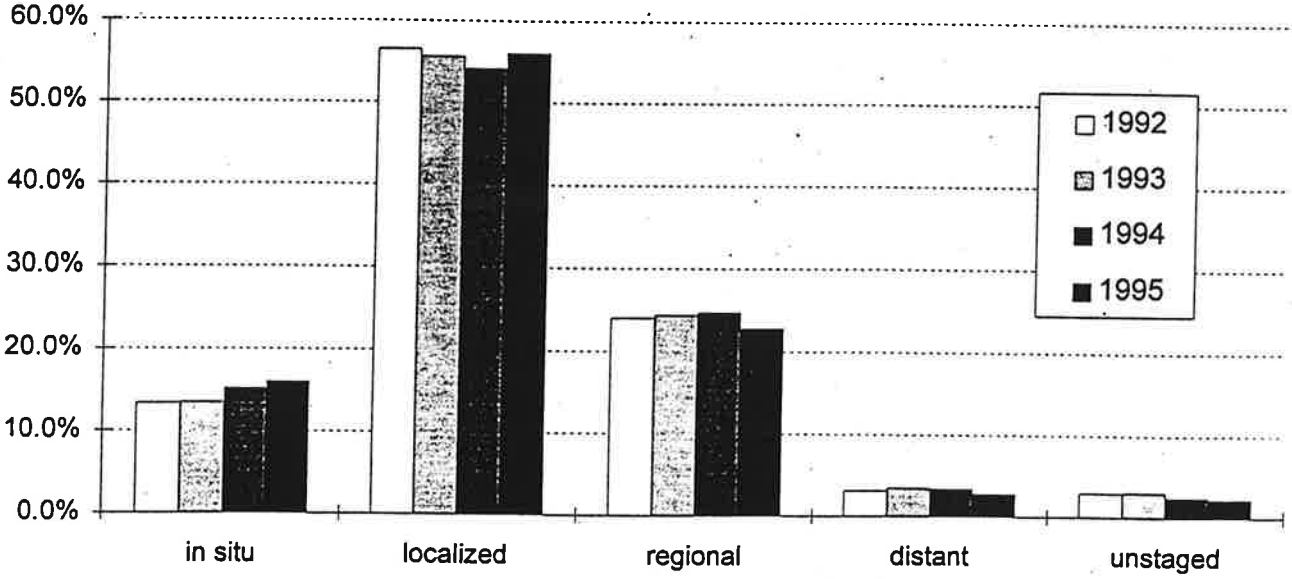
# BREAST CANCER INCIDENCE BY AGE AND STAGE OF DIAGNOSIS

## Female Breast Cancer Incidence
## Age-Adjusted Rate/100,000 in Washington State

using the 1970 Standard Population




## Stage of Diagnosis by Year, Washington State

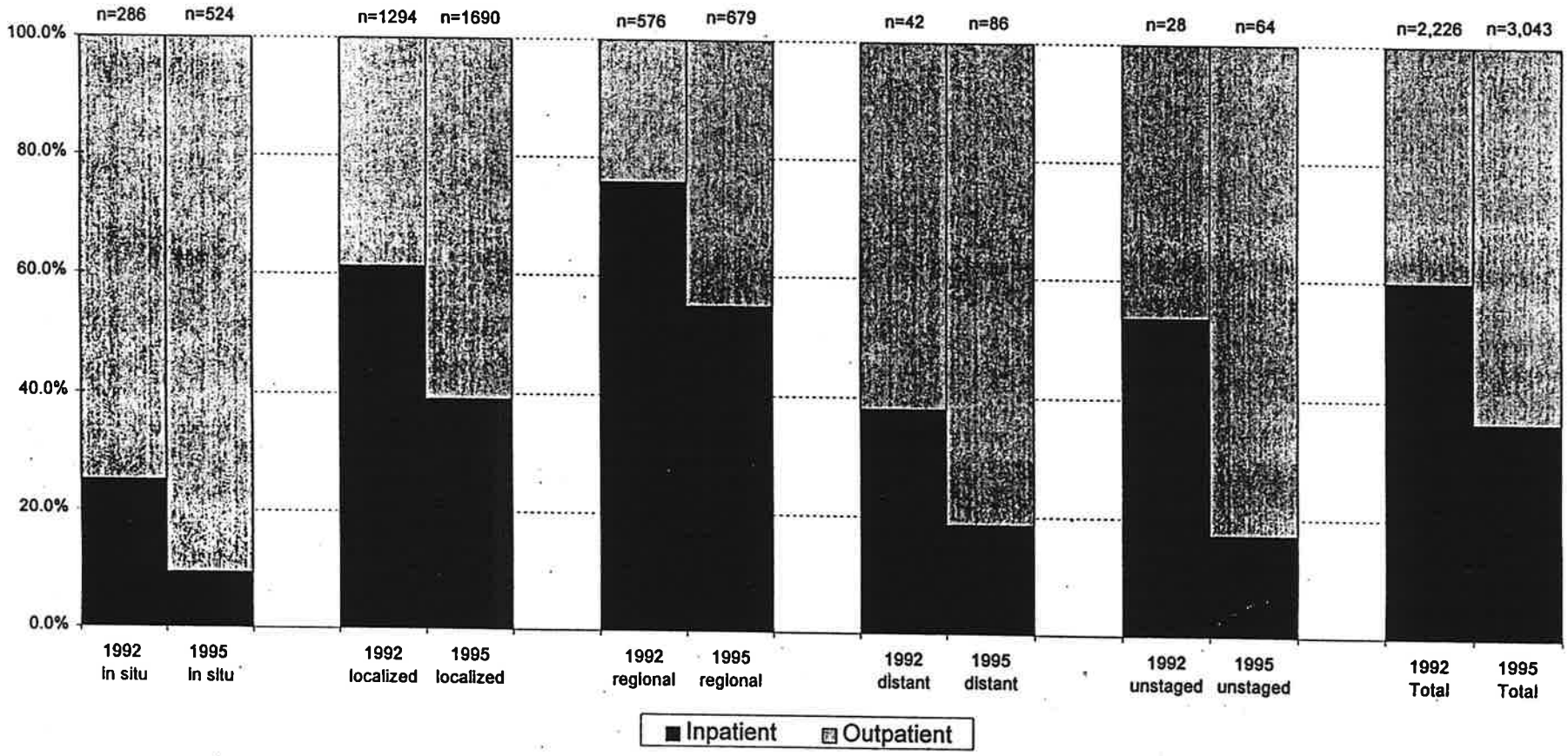



*Prepared by the Washington State Cancer Registry*

# APPENDIX D

# ESTIMATE OF INPATIENT AND OUTPATIENT MASTECTOMIES

# Washington State* Estimates of Inpatient and Outpatient Surgery for Breast Cancer Diagnosed in 1992** and 1995** by Stage at Diagnosis




* Excludes women from Island, Asotin, Clark, Skamania, Cowlitz, Klickitat and Wahkiakum counties.

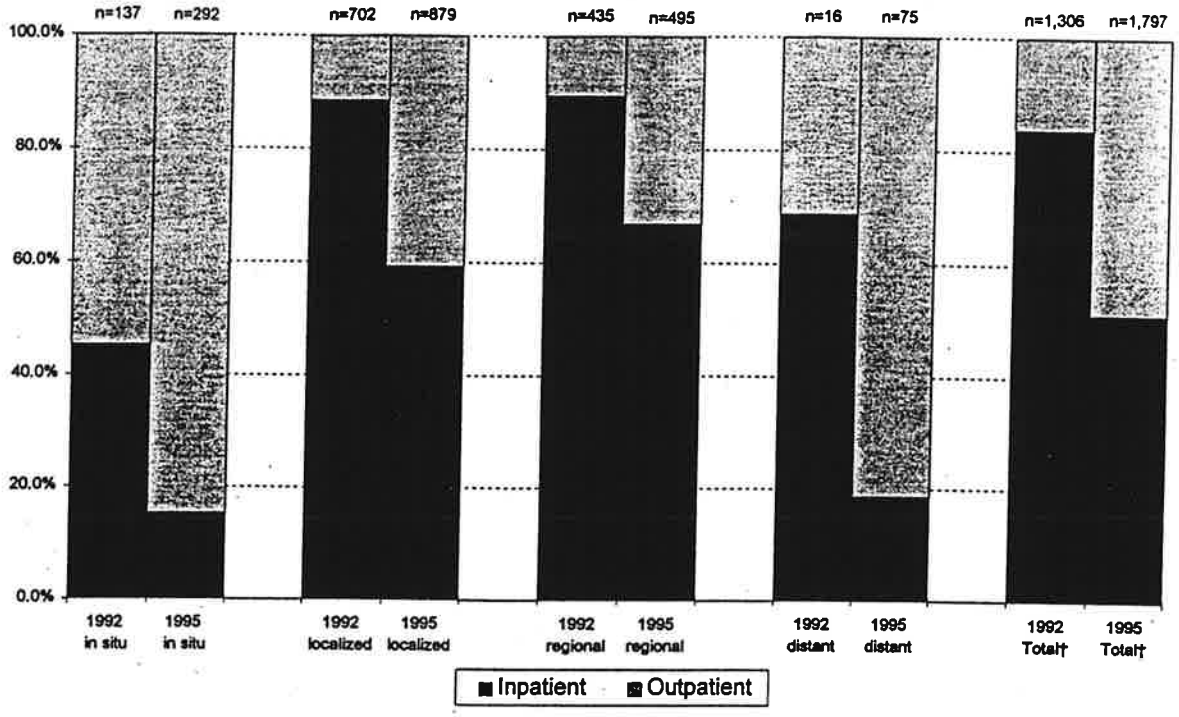
** Women diagnosed between January 1 and November 30 where first course of treatment included surgery.

*Prepared by the Washington State Cancer Registry from the Comprehensive Hospital Abstract Reporting System (CHARS) and Washington State Cancer Registry Data*

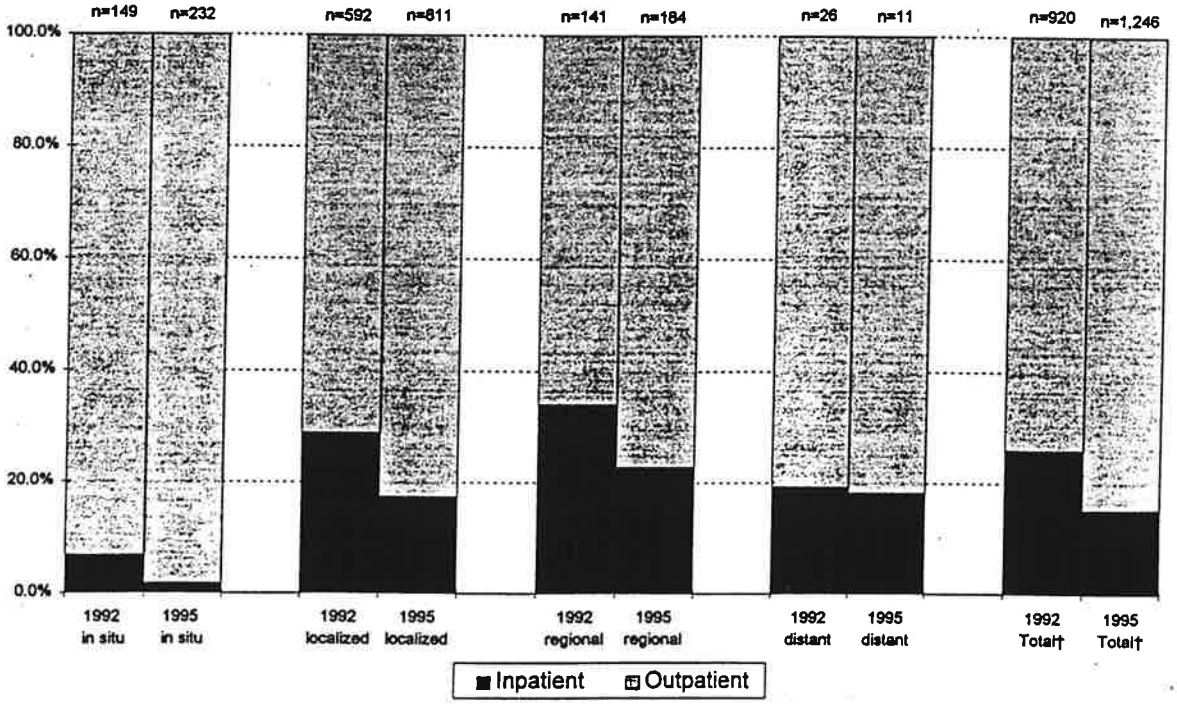
# APPENDIX E

# ESTIMATE OF INPATIENT AND OUTPATIENT MASTECTOMIES BY STAGE OF DIAGNOSIS

## Washington State* Estimates of Inpatient and Outpatient Mastectomy for Breast Cancer Diagnosed in 1992** and 1995** by Stage at Diagnosis




## Washington State* Estimates of Inpatient and Outpatient Lumpectomy for Breast Cancer Diagnosed in 1992** and 1995** by Stage at Diagnosis




* Excludes women from Island, Asotin, Clark, Skamania, Cowlitz, Klickitat and Wahkiakum counties.

** Women diagnosed between January 1 and November 30 where first course of treatment included surgery.

† Total includes unstaged cases.

*Prepared by the Washington State Cancer Registry from the Comprehensive Hospital Abstract Reporting System (CHARS) and Washington State Cancer Registry Data*

# APPENDIX F

# LENGTH OF STAY ALL SURGERIES, 1990-94, RANKED BY STATE

Length of Stay

| | 1994 | 1993 | 1992 | 1991 | 1990 |
|---|---|---|---|---|---|
| Alabama | 6.25 | 6.78 | 6.99 | 7.02 | 7.13 |
| Alaska | 6.43 | 6.60 | 6.63 | 5.72 | 5.80 |
| Arizona | 4.97 | 5.09 | 5.28 | 5.49 | 5.67 |
| Arkansas | 6.33 | 6.83 | 6.98 | 6.96 | 7.08 |
| California | 5.61 | 5.69 | 5.88 | 5.98 | 6.12 |
| Colorado | 6.21 | 6.46 | 6.60 | 6.76 | 7.20 |
| Connecticut | 7.28 | 7.23 | 7.21 | 7.41 | 7.62 |
| Delaware | 6.92 | 7.07 | 6.63 | 6.78 | 6.66 |
| District of Columbia | 6.96 | 7.15 | 7.36 | 7.50 | 7.93 |
| Florida | 6.31 | 6.61 | 6.95 | 7.04 | 6.96 |
| Georgia | 6.98 | 7.17 | 7.31 | 7.22 | 6.89 |
| Hawaii | 8.75 | 9.16 | 8.90 | 9.35 | 9.34 |
| Idaho | 6.51 | 6.90 | 6.98 | 7.09 | 6.73 |
| Illinois | 6.48 | 6.96 | 7.16 | 7.27 | 7.37 |
| Indiana | 6.05 | 6.40 | 6.54 | 6.63 | 6.65 |
| Iowa | 7.52 | 8.12 | 8.33 | 8.36 | 8.33 |
| Kansas | 7.45 | 7.71 | 7.82 | 7.83 | 7.86 |
| Kentucky | 6.56 | 6.78 | 6.96 | 6.90 | 6.73 |
| Louisiana | 6.37 | 6.63 | 6.55 | 6.66 | 6.59 |
| Maine | 7.14 | 7.58 | 7.67 | 7.93 | 8.06 |
| Maryland | 5.99 | 6.36 | 6.41 | 6.56 | 6.87 |
| Massachusetts | 6.35 | 6.73 | 6.90 | 7.03 | 7.30 |
| Michigan | 6.70 | 6.90 | 7.05 | 7.34 | 7.59 |
| Minnesota | 8.50 | 8.93 | 8.75 | 8.65 | 8.94 |
| Mississippi | 7.22 | 7.31 | 7.40 | 7.23 | 7.07 |
| Missouri | 6.89 | 7.20 | 7.37 | 7.41 | 7.45 |
| Montana | 10.43 | 10.15 | 9.96 | 10.04 | 9.82 |
| Nebraska | 10.01 | 9.62 | 9.61 | 9.56 | 9.63 |
| Nevada | 6.33 | 7.47 | 6.01 | 6.44 | 6.39 |
| New Hampshire | 7.19 | 7.14 | 7.08 | 7.02 | 6.79 |
| New Jersey | 7.51 | 7.91 | 8.09 | 7.58 | 7.46 |
| New Mexico | 5.31 | 5.38 | 5.41 | 5.50 | 5.74 |
| New York | 9.61 | 9.92 | 9.90 | 9.93 | 10.07 |
| North Carolina | 7.08 | 7.33 | 7.38 | 7.35 | 7.47 |
| North Dakota | 11.42 | 11.30 | 11.32 | 11.10 | 10.77 |
| Ohio | 6.18 | 6.42 | 6.53 | 6.64 | 6.74 |
| Oklahoma | 6.25 | 6.42 | 6.59 | 6.72 | 6.85 |
| Oregon | 5.09 | 5.06 | 5.05 | 5.33 | 5.54 |
| Pennsylvania | 7.14 | 7.72 | 7.59 | 7.55 | 7.76 |
| Rhode Island | 6.16 | 6.39 | 6.67 | 6.92 | 7.27 |
| South Carolina | 6.90 | 7.10 | 7.18 | 7.10 | 7.02 |
| South Dakota | 10.08 | 9.95 | 10.18 | 10.31 | 10.09 |
| Tennessee | 6.47 | 6.78 | 6.81 | 6.85 | 6.92 |
| Texas | 5.82 | 6.01 | 6.13 | 6.17 | 6.24 |
| Utah | 4.73 | 4.93 | 5.06 | 5.24 | 5.38 |
| Vermont | 8.30 | 7.88 | 7.03 | 7.64 | 7.30 |
| Virginia | 6.25 | 6.63 | 6.75 | 6.97 | 6.96 |
| Washington | 4.88 | 5.10 | 5.41 | 5.58 | 5.55 |
| West Virginia | 6.65 | 6.76 | 6.91 | 7.09 | 6.97 |
| Wisconsin | 6.89 | 7.20 | 7.28 | 7.28 | 7.39 |
| Wyoming | 8.76 | 9.02 | 8.64 | 8.55 | 8.77 |
| | | | | | |
| United States | 6.74 | 7.02 | 7.10 | 7.20 | 7.20 |

Source
AHA Aggregate Lotus Spreadsheets-
Annual Survey

allstate.ahasts
March, 1996

# APPENDIX G

# LENGTH OF STAY ALL SURGERIES, 1994, RANKED BY STATE

Length of Stay

| | 1994 |
|---|---|
| 1. Utah | 4.73 |
| 2. Washington | 4.88 |
| 3. Arizona | 4.97 |
| 4. Oregon | 5.09 |
| 5. New.Mexico | 5.31 |
| 6. California | 5.61 |
| 7. Texas | 5.82 |
| 8. Maryland | 5.99 |
| 9. Indiana | 6.05 |
| 10. Rhode Island | 6.16 |
| 11. Ohio | 6.18 |
| 12. Colorado | 6.21 |
| 13. Oklahoma | 6.25 |
| 14. Virginia | 6.25 |
| 15. Alabama | 6.25 |
| 16 Florida | 6.31 |
| 17. Arkansas | 6.33 |
| 18. Nevada | 6.33 |
| 19. Massachusetts | 6.35 |
| 20. Louisiana | 6.37 |
| 21. Alaska | 6.43 |
| 22. Tennessee | 6.47 |
| 23. Illinois | 6.48 |
| 24. Idaho | 6.51 |
| 25. Kentucky | 6.56 |
| 26. West Virginia | 6.65 |
| 27. Michigan | 6.70 |
| 28. United States | 6.74 |
| 29. Missouri | 6.89 |
| 30 Wisconsin | 6.89 |
| 31. South Carolina | 6.90 |
| 32. Delaware | 6.92 |
| 33. District of Columbia | 6.96 |
| 34. Georgia | 6.98 |
| 35. North Carolina | 7.08 |
| 36. Pennsylvania | 7.14 |
| 37. Maine | 7.14 |
| 38. New Hampshire | 7.19 |
| 39. Mississippi | 7.22 |
| 40. Connecticut | 7.28 |
| 41. Kansas | 7.45 |
| 42. New Jersey | 7.51 |
| 43. Iowa | 7.52 |
| 44. Vermont | 8.30 |
| 45. Minnesota | 8.50 |
| 46. Hawaii | 8.75 |
| 47. Wyoming | 8.76 |
| 48. New York | 9.61 |
| 49. Nebraska | 10.01 |
| 50 South Dakota | 10.08 |
| 51. Montana | 10.43 |
| 52. North Dakota | 11.42 |

Source
AHA Aggregate Lotus Spreadsheets-
Annual Survey

allstate.ahasts
March, 1996

# APPENDIX H

# 1991, 1993, 1995, 1996 CHARS DATA: MASTECTOMY LOS BY PAYER

# 1990, 1993, 1995 and 1996 Statewide CHARS Mastectomy Data, Length of Stay (LOS) by Payer

| Primary Procedure | Year | Length of Stay | | | | Length of Stay by Payer | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | All Cases, All Payers | | | | Medicare | | | | Health Maintenance Org | | | | Other Non-Government Ins. | | | |
| | | Total | | LOS < 2 Days | | Total | | LOS < 2 Days | | | | LOS < 2 Days | | | | LOS < 2 Days | |
| | | Cases | ALOS | Cases | % | Cases | ALOS | Cases | % | Cases | ALOS | Cases | % | Cases | ALOS | Cases | % |
| 85.41 Unilateral Simple Mastectomy | 1990 | 246 | 2.5 | 57 | 23% | 99 | 2.7 | 21 | 21% | 31 | 2.6 | 5 | | 96 | 2.2 | 28 | 29% |
| | 1993 | 255 | 2.3 | 101 | 40% | 78 | 2.4 | 27 | 35% | 42 | 2.1 | 19 | 45% | 123 | 2.1 | 51 | 41% |
| | 1995 | 264 | 2.0 | 150 | 57% | 96 | 2.3 | 47 | 49% | 41 | 1.8 | 22 | 54% | 113 | 1.7 | 73 | 65% |
| | 1996 | 205 | 2.0 | 104 | 51% | 80 | 1.9 | 38 | 48% | 42 | 2.0 | 24 | 57% | 70 | 2.1 | 34 | 49% |
| 85.42 Bilateral Simple Mastectomy | 1990 | 48 | 3.2 | 2 | | 4 | 4.3 | 0 | | 14 | 2.9 | 0 | | 24 | 3.0 | 2 | |
| | 1993 | 43 | 2.2 | 11 | 26% | 4 | 2.0 | 1 | | 9 | 2.1 | 3 | | 24 | 2.3 | 5 | |
| | 1995 | 33 | 2.2 | 9 | 27% | 5 | 2.2 | 1 | | 10 | 2.0 | 4 | | 15 | 2.3 | 3 | |
| | 1996 | 36 | 2.3 | 10 | 28% | 5 | 2.2 | 3 | | 9 | 1.9 | 4 | | 17 | 2.7 | 1 | |
| 85.43 Unilateral Extended Simple Mastectomy** | 1990 | 1,783 | 2.7 | 173 | 10% | 819 | 2.9 | 66 | 8% | 188 | 2.6 | 12 | 6% | 615 | 2.6 | 71 | 12% |
| | 1993 | 1,688 | 2.2 | 413 | 24% | 749 | 2.3 | 176 | 23% | 179 | 2.1 | 41 | 23% | 619 | 2.0 | 160 | 26% |
| | 1995 | 1,309 | 1.9 | 572 | 44% | 605 | 2.0 | 248 | 41% | 147 | 1.8 | 68 | 46% | 447 | 1.9 | 213 | 48% |
| | 1996 | 1,089 | 1.9 | 483 | 44% | 472 | 2.0 | 188 | 40% | 173 | 1.7 | 87 | 50% | 359 | 1.8 | 172 | 48% |
| 85.43 Unilateral Extended Simple Mastectomy** where the 2nd procedure is 85.41 | 1990 | 32 | 2.9 | 1 | | 8 | 2.5 | 0 | | 4 | 3.8 | 0 | | 18 | 3.1 | 0 | |
| | 1993 | 46 | 2.9 | 1 | | 10 | 3.1 | 1 | | 7 | 3.0 | 0 | | 26 | 2.7 | 0 | |
| | 1995 | 57 | 2.1 | 13 | 23% | 8 | 2.4 | 1 | | 15 | 2.2 | 4 | | 28 | 2.1 | 6 | 21% |
| | 1996 | 60 | 2.1 | 22 | 37% | 12 | 2.0 | 4 | | 8 | 1.8 | 5 | | 36 | 2.2 | 12 | 33% |
| 85.44 Bilateral Extended Simple Mastectomy** | 1990 | 35 | 3.4 | 2 | | 11 | 3.5 | 0 | | 1 | 4.0 | 0 | | 22 | 3.3 | 2 | |
| | 1993 | 36 | 2.9 | 1 | | 18 | 2.8 | 0 | | 2 | 3.0 | 0 | | 14 | 3.1 | 1 | |
| | 1995 | 31 | 2.4 | 7 | 23% | 10 | 2.4 | 2 | | 3 | 1.3 | 2 | | 10 | 2.8 | 2 | |
| | 1996 | 32 | 2.4 | 6 | 19% | 14 | 2.4 | 2 | | 3 | 2.3 | 0 | | 13 | 2.5 | 3 | |
| 85.45 Unilateral Radical Mastectomy*** | 1990 | 39 | 2.8 | 4 | | 15 | 3.0 | 1 | | 7 | 3.1 | 1 | | 15 | 2.2 | 2 | |
| | 1993 | 31 | 2.7 | 3 | | 9 | 3.2 | 0 | | 3 | 2.3 | 0 | | 12 | 2.1 | 3 | |
| | 1995 | 25 | 3.0 | 5 | | 10 | 2.6 | 0 | | 2 | 10.0 | 1 | | 12 | 2.1 | 4 | |
| | 1996 | 19 | 4.3 | 8 | 42% | 2 | 15.5 | 0 | | 6 | 2.5 | 4 | | 10 | 3.6 | 3 | |
| Total* | 1990 | 2,190 | 2.7 | 239 | 11% | 961 | 2.9 | 88 | 9% | 246 | 2.7 | 18 | 7% | 791 | 2.5 | 105 | 13% |
| | 1993 | 2,104 | 2.2 | 530 | 25% | 870 | 2.4 | 205 | 24% | 242 | 2.1 | 63 | 26% | 820 | 2.0 | 220 | 27% |
| | 1995 | 1,727 | 2.0 | 757 | 44% | 736 | 2.0 | 299 | 41% | 219 | 1.9 | 101 | 46% | 630 | 1.9 | 302 | 48% |
| | 1996 | 1,444 | 2.0 | 634 | 44% | 586 | 2.0 | 236 | 40% | 242 | 1.8 | 124 | 51% | 506 | 1.9 | 225 | 44% |

* Includes cases for all payers. We chose payers with the largest number to present separately. (In 1996 66 patients were covered by Medicaid.)

*Includes ICD-9 Codes: 85.41-85.48. The ICD-9 codes 85.46, 85.47, 85.48 are not presented separately due to small numbers. (For example in 1996: 85.46 - 2 cases, 85.47 - 1 case, 85.48 - 0 cases)

** ICD-9 Codes 85.43 and 85.44 include Modified radical mastectomy and Simple mastectomy with excision of regional lymph nodes.

*** ICD-9 Code 85.45 includes Excision of breast, pectoral muscles, and regional lymph nodes [axillary, clavicular, supraclavicular].

ICD-9 Code 85.46 Bilateral radical mastectomy

ICD-9 Code 85.47 Unilateral extended radical mastectomy which includes Excision of breast, muscles, and lymph nodes [axillary, clavicular, supraclavicular, internal mammary, and mediastinal]

ICD-9 Code 85.48 Bilateral extended radical mastectomy

‡ Percentages were not calculated when numbers were < 6.

*Prepared by: Office of Hospital Patient Data Systems/Office of Epidemiology, WA State Department of Health*

MASTEC3.XLS, 12/5/1997

# APPENDIX I

# 1991, 1993, 1995, 1996 CHARS DATA: MASTECTOMY LOS BY AGE GROUP

# 1990, 1993, 1995 and 1996 Statewide CHARS Mastectomy Data, Length of Stay (LOS) by Age Group

| Primary Procedure | Year | Length of Stay | | | | Length of Stay by Age Group | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | All Cases | | | | 0-44 | | | | 45-64 | | | | 65+ | | | |
| | | Total | | LOS < 2 Days | | Total | | LOS < 2 Days | | | | LOS < 2 Days | | | | LOS < 2 Days | |
| | | Cases | ALOS | Cases | %‡ | Cases | ALOS | Cases | %‡ | Cases | ALOS | Cases | %‡ | Cases | ALOS | Cases | %‡ |
| 85.41 Unilateral Simple Mastectomy | 1990 | 246 | 2.5 | 57 | 23% | 43 | 2.2 | 9 | 21% | 90 | 2.5 | 23 | 26% | 113 | 2.6 | 25 | 22% |
| | 1993 | 255 | 2.3 | 101 | 40% | 61 | 2.5 | 22 | 36% | 96 | 2.1 | 45 | 47% | 98 | 2.3 | 34 | 35% |
| | 1995 | 264 | 2.0 | 150 | 57% | 44 | 2.2 | 20 | 45% | 113 | 1.8 | 72 | 64% | 107 | 2.1 | 58 | 54% |
| | 1996 | 205 | 2.0 | 104 | 51% | 41 | 2.9 | 16 | 39% | 81 | 1.8 | 38 | 47% | 93 | 1.8 | 50 | 54% |
| 85.42 Bilateral Simple Mastectomy | 1990 | 48 | 3.2 | 2 | | 17 | 3.5 | 0 | | 24 | 2.7 | 2 | | 7 | 4.3 | 0 | |
| | 1993 | 43 | 2.2 | 11 | 26% | 17 | 2.6 | 4 | | 24 | 2.0 | 6 | 25% | 2 | 1.5 | 1 | |
| | 1995 | 33 | 2.2 | 9 | 27% | 15 | 2.3 | 5 | | 13 | 2.2 | 2 | | 5 | 1.8 | 2 | |
| | 1996 | 36 | 2.3 | 10 | 28% | 11 | 2.5 | 2 | | 18 | 2.4 | 3 | | 7 | 1.9 | 5 | |
| 85.43 Unilateral Extended Simple Mastectomy** | 1990 | 1,783 | 2.7 | 173 | 10% | 210 | 2.7 | 21 | 10% | 680 | 2.6 | 81 | 12% | 893 | 2.9 | 71 | 8% |
| | 1993 | 1,688 | 2.2 | 413 | 24% | 138 | 2.2 | 59 | 43% | 624 | 2.0 | 166 | 27% | 826 | 2.3 | 188 | 23% |
| | 1995 | 1,309 | 1.9 | 572 | 44% | 167 | 1.9 | 81 | 49% | 488 | 1.9 | 221 | 45% | 654 | 2.0 | 270 | 41% |
| | 1996 | 1,089 | 1.9 | 483 | 44% | 117 | 1.8 | 55 | 47% | 437 | 1.8 | 213 | 49% | 535 | 1.9 | 215 | 40% |
| 85.43 Unilateral Extended Simple Mastectomy** where the 2nd procedure is 85.41 | 1990 | 32 | 2.9 | 1 | | 5 | 3.4 | 0 | | 19 | 3.0 | 1 | | 8 | 2.5 | 0 | |
| | 1993 | 46 | 2.9 | 1 | | 8 | 2.9 | 0 | | 26 | 2.7 | 0 | | 12 | 3.3 | 1 | |
| | 1995 | 57 | 2.1 | 13 | 23% | 16 | 2.3 | 3 | | 33 | 2.0 | 9 | 27% | 8 | 2.4 | 1 | |
| | 1996 | 60 | 2.1 | 22 | 37% | 13 | 1.7 | 8 | 62% | 33 | 2.4 | 9 | 27% | 14 | 2.0 | 5 | |
| 85.44 Bilateral Extended Simple Mastectomy** | 1990 | 35 | 3.4 | 2 | | 7 | 3.4 | 0 | | 16 | 3.2 | 2 | | 12 | 3.6 | 0 | |
| | 1993 | 36 | 2.9 | 1 | | 8 | 2.5 | 1 | | 8 | 2.8 | 0 | | 20 | 2.8 | 0 | |
| | 1995 | 31 | 2.4 | 7 | 23% | 6 | 2.5 | 0 | | 17 | 2.3 | 5 | | 8 | 2.4 | 2 | |
| | 1996 | 32 | 2.4 | 6 | 19% | 3 | 2.3 | 0 | | 15 | 2.3 | 4 | | 14 | 2.4 | 2 | |
| 85.45 Unilateral Radical Mastectomy*** | 1990 | 39 | 2.8 | 4 | | 4 | 2.8 | 0 | | 15 | 2.5 | 3 | | 20 | 3.2 | 1 | |
| | 1993 | 31 | 2.7 | 3 | | 4 | 2.5 | 1 | | 16 | 2.6 | 2 | | 11 | 3.1 | 0 | |
| | 1995 | 25 | 3.0 | 5 | | 2 | 1.5 | 1 | | 13 | 3.6 | 4 | | 10 | 2.4 | 0 | |
| | 1996 | 19 | 4.3 | 8 | 42% | 4 | 4.5 | 1 | | 11 | 2.8 | 5 | | 4 | 8.3 | 2 | |
| Total* | 1990 | 2,190 | 2.7 | 239 | 11% | 287 | 2.7 | 30 | 10% | 845 | 2.6 | 112 | 13% | 1,058 | 2.9 | 97 | 9% |
| | 1993 | 2,104 | 2.2 | 530 | 25% | 337 | 2.3 | 87 | 26% | 797 | 2.1 | 219 | 27% | 970 | 2.3 | 224 | 23% |
| | 1995 | 1,727 | 2.0 | 757 | 44% | 252 | 2.0 | 110 | 44% | 681 | 1.9 | 314 | 46% | 794 | 2.0 | 333 | 42% |
| | 1996 | 1,444 | 2.0 | 634 | 44% | 190 | 2.1 | 82 | 43% | 586 | 1.9 | 272 | 46% | 668 | 2.0 | 280 | 42% |

*Includes ICD-9 Codes: 85.41-85.48. The ICD-9 codes 85.46, 85.47, 85.48 are not presented separately due to small numbers. (For example in 1996: 85.46 - 2 cases, 85.47 - 1 case, 85.48 - 0 cases)

**ICD-9 Codes 85.43 and 85.44 include Modified radical mastectomy and Simple mastectomy with exclsion of regional lymph nodes.

***ICD-9 Code 85.45 includes Excision of breast, pectoral muscles, and regional lymph nodes [axillary, clavicular, supraclavicular].

ICD-9 Code 85.46 Bilateral radical mastectomy

ICD-9 Code 85.47 Unilateral extended radical mastectomy which includes Excision of breast, muscles, and lymph nodes [axillary, clavicular, supraclavicular, internal mammary, and mediastinal]

ICD-9 Code 85.48 Bilateral extended radical mastectomy

‡ Percentages were not calculated when numbers were < 6.

*Prepared by: Office of Hospital Patient Data Systems/Office of Epidemiology, WA State Department of Health*

MASTEC3.XLS, 12/5/1997

# APPENDIX J

# 1991, 1993, 1995, 1996 CHARS DATA: MASTECTOMY READMISION BY PAYER

# 1990, 1993, 1995 and 1996 Statewide CHARS Mastectomy Data, Readmissions by Payer

| Primary Procedure | Year | Readmissions | | | | | | | | Readmissions by Payer | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | All Cases | | | | Medicare | | | | Health Maintenance Org | | | | Other Non-Government Insurance | | | | | |
| | | Cases | 0-7 days Cases | 0-7 days % | 0-14 days Cases | 0-14 days % | Cases | 0-7 days Cases | 0-7 days % | 0-14 days Cases | 0-14 days % | Cases | 0-7 days Cases | 0-7 days % | 0-14 days Cases | 0-14 days % | Cases | 0-7 days Cases | 0-7 days % | 0-14 days Cases | 0-14 days % |
| 85.41 Unilateral Simple Mastectomy | 1990 | 1,246 | 3 | | 9 | 4% | 99 | 1 | | 4 | | 31 | 0 | | 1 | | 96 | 2 | | 4 | |
| | 1993 | 255 | 4 | | 7 | 3% | 78 | 3 | | 3 | | 42 | 0 | | 0 | | 123 | 1 | | 2 | |
| | 1995 | 264 | 6 | 2% | 11 | 4% | 96 | 1 | | 3 | | 41 | 3 | | 5 | | 113 | 2 | | 3 | |
| 85.42 Bilateral Simple Mastectomy | 1990 | 48 | 2 | | 3 | | 4 | 0 | | 0 | | 14 | 0 | | 1 | | 24 | 1 | | 1 | |
| | 1993 | 43 | 3 | | 6 | 14% | 4 | 3 | | 3 | | 9 | 0 | | 2 | | 24 | 0 | | 0 | |
| | 1995 | 33 | 1 | | 1 | | 5 | 0 | | 0 | | 10 | | | | | 15 | 1 | | 1 | |
| 85.43 Unilateral Extended Simple Mastectomy** | 1990 | 1,783 | 52 | 3% | 82 | 5% | 819 | 28 | 3% | 37 | 5% | 188 | 3 | | 6 | 3% | 615 | 17 | 3% | 23 | 4% |
| | 1993 | 1,688 | 61 | 4% | 101 | 6% | 749 | 19 | 3% | 40 | 5% | 179 | 8 | 4% | 10 | 6% | 619 | 27 | 4% | 41 | 7% |
| | 1995 | 1,309 | 40 | 3% | 69 | 5% | 605 | 14 | 2% | 32 | 5% | 147 | 5 | | 5 | | 447 | 14 | 3% | 20 | 4% |
| 85.43 Unilateral Extended Simple Mastectomy** where the 2nd procedure is 85.41 | 1990 | 32 | 1 | | 2 | | 8 | 0 | | 0 | | 4 | 0 | | 0 | | 18 | 1 | | 1 | |
| | 1993 | 46 | 2 | | 2 | | 10 | 0 | | 0 | | 7 | | | 1 | | 26 | 2 | | 2 | |
| | 1995 | 57 | 5 | | 5 | | 8 | 0 | | 0 | | 15 | | | | | 28 | 5 | | 5 | |
| 85.44 Bilateral Extended Simple Mastectomy** | 1990 | 35 | 0 | | 0 | | 11 | | | | | 1 | 0 | | 0 | | 22 | 0 | | 0 | |
| | 1993 | 36 | 5 | | 6 | 17% | 18 | 4 | | 5 | | 2 | | | | | 14 | 0 | | 1 | |
| | 1995 | 31 | 1 | | 3 | | 10 | 1 | | 1 | | 3 | | | | | 10 | 0 | | 2 | |
| 85.45 Unilateral Radical Mastectomy*** | 1990 | 39 | 1 | | 1 | | 15 | 0 | | 0 | | 7 | 0 | | 0 | | 15 | 1 | | 1 | |
| | 1993 | 31 | 2 | | 2 | | 9 | 2 | | 2 | | 3 | | | | | 12 | 0 | | 0 | |
| | 1995 | 25 | 1 | | 1 | | 10 | 1 | | 1 | | 2 | | | | | 12 | 0 | | 0 | |
| Total* | 1990 | 2,190 | 59 | 3% | 97 | 4% | 961 | 29 | 3% | 41 | 4% | 246 | 3 | | 8 | 3% | 791 | 22 | 3% | 30 | 4% |
| | 1993 | 2,104 | 76 | 4% | 124 | 6% | 870 | 31 | 4% | 53 | 6% | 242 | 8 | 3% | 12 | 5% | 810 | 30 | 4% | 46 | 6% |
| | 1995 | 1,727 | 54 | 3% | 90 | 5% | 736 | 17 | 2% | 37 | 5% | 219 | 8 | 4% | 10 | 5% | 630 | 22 | 3% | 29 | 5% |

* Includes cases for all payers. We chose payers with the largest number to present separately. (In 1995 42 patients were readmitted under Medicaid coverage.)

*Includes ICD-9 Codes: 85.41-85.48. The ICD-9 codes 85.46, 85.47, 85.48 are not presented separately due to small numbers. (For example in 1995: 85.46 - 0 cases, 85.47 - 0 cases, 85.48 - 0 cases)

**ICD-9 Codes 85.43 and 85.44 include Modified radical mastectomy and Simple mastectomy with excision of regional lymph nodes.

***ICD-9 Code 85.45 includes Excision of breast, pectoral muscles, and regional lymph nodes [axillary, clavicular, supraclavicular].

ICD-9 Code 85.46 Bilateral radical mastectomy

ICD-9 Code 85.47 Unilateral extended radical mastectomy which includes Excision of breast, muscles, and lymph nodes [axillary, clavicular, supraclavicular, internal mammary, and mediastinal]

ICD-9 Code 85.48 Bilateral extended radical mastectomy

‡ Percentages were not calculated when numbers were < 6.

# APPENDIX K

# 1991, 1993, 1995, 1996 CHARS DATA: MASTECTOMY READMISION BY AGE GROUP

# 1990, 1993, 1995 and 1996 Statewide CHARS Mastectomy Data, Readmissions by Age Group

| Primary Procedure | Year | Readmissions | | | | | Readmissions by Age Group | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | All Cases | | | | | 0-44 | | | | | 45-64 | | | | | 65+ | | | | |
| | | | 0-7 days | | 0-14 days | | | 0-7 days | | 0-14 days | | | 0-7 days | | 0-14 days | | | 0-7 days | | 0-14 days | |
| | | Cases | Cases | %‡ | Cases | %‡ | Cases | Cases | %‡ | Cases | %‡ | Cases | Cases | %‡ | Cases | %‡ | Cases | Cases | %‡ | Cases | %‡ |
| 85.41 Unilateral Simple Mastectomy | 1990 | 246 | 3 | | 9 | 4% | 43 | 0 | | 1 | | 90 | 1 | | 2 | | 113 | 2 | | 6 | 5% |
| | 1993 | 255 | 4 | | 7 | 3% | 61 | 1 | | 1 | | 96 | 0 | | 3 | | 98 | 3 | | 3 | |
| | 1995 | 264 | 6 | 2% | 11 | 4% | 44 | 4 | | 5 | | 113 | 1 | | 2 | | 107 | 1 | | 4 | |
| 85.42 Bilateral Simple Mastectomy | 1990 | 48 | 2 | | 3 | | 17 | 1 | | 1 | | 24 | 1 | | 2 | | 7 | 0 | | 0 | |
| | 1993 | 43 | 3 | | 6 | 14% | 17 | 0 | | 1 | | 24 | 3 | | 5 | | 2 | 0 | | 0 | |
| | 1995 | 33 | 1 | | 1 | | 15 | 1 | | 1 | | 13 | 0 | | 0 | | 5 | 0 | | 0 | |
| 85.43 Unilateral Extended Simple Mastectomy** | 1990 | 1,783 | 52 | 3% | 82 | 5% | 210 | 7 | 3% | 17 | 8% | 680 | 19 | 3% | 29 | 4% | 893 | 26 | 3% | 36 | 4% |
| | 1993 | 1,688 | 61 | 4% | 101 | 6% | 138 | 16 | 12% | 24 | 17% | 624 | 25 | 4% | 37 | 6% | 826 | 20 | 2% | 40 | 5% |
| | 1995 | 1,309 | 40 | 3% | 69 | 5% | 167 | 8 | 5% | 15 | 9% | 488 | 17 | 3% | 21 | 4% | 654 | 15 | 2% | 33 | 5% |
| 85.43 Unilateral Extended Simple Mastectomy** where the 2nd procedure is 85.41 | 1990 | 32 | 1 | | 2 | | 5 | 1 | | 1 | | 19 | 0 | | 1 | | 8 | 0 | | 0 | |
| | 1993 | 46 | 2 | | 2 | | 8 | 0 | | 0 | | 26 | 2 | | 2 | | 12 | 0 | | 0 | |
| | 1995 | 57 | 5 | | 5 | | 16 | 0 | | 0 | | 33 | 5 | | 5 | | 8 | 0 | | 0 | |
| 85.44 Bilateral Extended Simple Mastectomy** | 1990 | 35 | 0 | | 0 | | 7 | 0 | | 0 | | 16 | 0 | | 0 | | 12 | 0 | | 0 | |
| | 1993 | 36 | 5 | | 6 | 17% | 8 | 0 | | 0 | | 8 | 0 | | 1 | | 20 | 4 | | 5 | |
| | 1995 | 31 | 1 | | 3 | | 6 | 0 | | 0 | | 17 | 0 | | 2 | | 8 | 1 | | 1 | |
| 85.45 Unilateral Radical Mastectomy*** | 1990 | 39 | 1 | | 1 | | 4 | 0 | | 0 | | 15 | 1 | | 1 | | 20 | 0 | | 0 | |
| | 1993 | 31 | 2 | | 2 | | 4 | 0 | | 0 | | 16 | 0 | | 0 | | 11 | 2 | | 2 | |
| | 1995 | 25 | 1 | | 1 | | 2 | 0 | | 0 | | 13 | 1 | | 1 | | 10 | 0 | | 0 | |
| Total* | 1990 | 2,190 | 59 | 3% | 97 | 4% | 287 | 9 | 3% | 20 | 7% | 845 | 2 | | 35 | 4% | 1,058 | 28 | 3% | 42 | 4% |
| | 1993 | 2,104 | 76 | 4% | 124 | 6% | 337 | 17 | 5% | 26 | 8% | 797 | 30 | 4% | 48 | 6% | 970 | 29 | 3% | 50 | 5% |
| | 1995 | 1,727 | 54 | 3% | 90 | 5% | 252 | 13 | 5% | 21 | 8% | 681 | 24 | 4% | 31 | 5% | 794 | 17 | 2% | 38 | 5% |

*Includes ICD-9 Codes: 85.41-85.48. The ICD-9 codes 85.46, 85.47, 85.48 are not presented separately due to small numbers. (For example in 1995: 85.46 - 0 cases, 85.47 - 0 cases, 85.48 - 0 cases)

**ICD-9 Codes 85.43 and 85.44 include Modified radical mastectomy and Simple mastectomy with excision of regional lymph nodes.

***ICD-9 Code 85.45 includes Excision of breast, pectoral muscles, and regional lymph nodes [axillary, clavicular, supraclavicular].

ICD-9 Code 85.46 Bilateral radical mastectomy

ICD-9 Code 85.47 Unilateral extended radical mastectomy which includes Excision of breast, muscles, and lymph nodes [axillary, clavicular, supraclavicular, internal mammary, and mediastinal]

ICD-9 Code 85.48 Bilateral extended radical mastectomy

‡ Percentages were not calculated when numbers were < 6.

# APPENDIX L

# LITERATURE REVIEW: DETAILED

## LITERATURE REVIEW:

### A. Background on Trends and Short-Stay or Outpatient Surgery in General

There is a trend toward moving surgical procedures to an outpatient basis or shortened length of hospital stay. This is being driven by a number of factors, most notably the advancement of surgical technology, new types of anesthesia and methods of administration, and changes in recovery practices. This is a natural result of improvements in medical practice.

Studies have shown a wide variety of procedures can be done on an outpatient basis or with a shortened length of stay (over historical levels) without increasing morbidity. For example, a study on discharge for prostatectomy found that "reduced hospital length of stay after radical retropubic prostatectomy results in significant cost savings without increasing morbidity." (Licht/Klein 1994). An article in 1996 addressed ways to safely perform prostatectomies on an outpatient basis.

Same day surgery (defined as 23 hours or less observation following surgery) for thyroid problems was subjected to a retrospective review in 1993. Out of a total of 80 patients, 71 patients were involved in outpatient procedures, of whom 47 had near-total or total thyroidectomy, 20 had lobectomy. Eleven patients had some post surgical morbidity reported, notably transient hypocalcemia in eight patients. Cost reductions ranged from 32% to 56%. "Same day thyroid surgery is a safe and cost-effective approach for patients with nodular thyroid disease." (McHenry 1997)

A University of Texas team reviewed outpatient orthognathic surgery from 1988 to 1995, involving 205 patients (out of 328 total orthognathic patients). The team concluded that "the number and complexity of orthognathic procedures increased dramatically over the study period." The researchers found that a few hospital admissions following surgery were not due to the complexity of the procedure, but rather the length of anesthesia time. There were few unexpected complications, with considerable cost reduction and convenience for the patients." (Lupori et al, 1997)

A study concerning hip fractures found that "hospitals differed widely in their mean length of stay for hip fracture patients, and severity adjustment did little to explain these differences." (Shwartz, et al, 1995) Improvements in analgesia practices are credited toward allowing safe, same day, testicular surgeries. (Burden, et al 1997)

Other common surgeries moving to the ambulatory setting are: hemorrhoidectomy, pacemaker insertion, laparotomy, vaginal hysterectomy, abdominal hernia repair, removal of fallopian tubes and ovaries. (HCIA, Inc.)

An international study, published in an Italian journal, states that "ambulatory surgery proves its value on the clinical and socio-economic grounds provided that a well organized program and careful selection of patients is adopted. Results of surgery are satisfactory supporting the advantage of ambulatory surgery such as the absence of complications due to anesthesia and hospital stay, the better relationship between patient and surgeon, the short return to working activities." (Sias, et al, 1996)

The length of stay or outpatient basis needs to be looked at in the context of other aspects, such as pre-operative instructions and post-operative care. "While the quality of medical intervention associated with day surgery has greatly improved, the position of psychological preparation has remained virtually unchanged. Recent evidence, however, has suggested that anxiety levels can be significantly reduced if preparatory information can be matched with individual coping styles." (Mitchell, 1997).

Other authors have found other reasons that day surgery has not grown as fast as medical knowledge would otherwise allow. "New technologies, new surgical procedures, new anesthetics and new analgesics are not required to achieve a marked increase in day surgery in the near future. The reason why some hospitals perform little or no day surgery...is a negative attitude by consultants in these units." (Jarrett, 1995) The solution, Jarrett states, is better education of surgeons. Factors such as obesity can contribute to surgical risk in cancer patients as much as length and type of procedure. (Barber, et al, 1995)

The dangers associated with nosocomial infections are another factor making shorter lengths of stay or outpatient procedures more attractive, although the tradeoff should not be too short a stay that produces significant morbidity increases. (Various sources)

B. Clinical and Research Literature Specific to Mastectomy

Johns Hopkins University has developed an outpatient mastectomy program. In 1994, when the program began, 20 percent of patients opted to participate in the voluntary program. In 1996 that percentage rose to 70%. The "vital key" to outpatient mastectomy, according to the director of the Johns Hopkins Breast Center, Dr. William Dooley, is "preparation. Social, psychological and emotional preparation....it is possible to feel good about going home." Another benefit is that "hospitals are not the same places they used to be in 'Marcus Welby'. With managed care dictating shorter hospitals

stays, there is an increased acuity of care. Hospital floors are full of sick people, not the place for mastectomy patients." Due to the rise of antibacterial resistant diseases in hospital settings, "it is better to have clean, elective surgery out of hospitals." (Read, 1997)

A study published in 1992 compared mastectomy patients who chose early discharge (2 days) with drains in place, to those patients who stayed (6 days) until the drain was removed. There "were no differences between the groups in type of incidence of complications, and the groups were equally satisfied with their length of hospital stay and the treatment in hospital. Those who opted for early discharge were significantly younger than those who did not (52 versus 62)." The conclusion was that "early discharge from hospital with the drain still in place...was not found to be associated with any untoward risks." (Boman, et all, 1992)

Other studies point out benefits of early discharge for mastectomy patients. Kambouris (1996) reports that a program that uses outpatient and short hospital stays has led to "significant cost savings...to better physical and psychological recovery, emphasizing patient comfort, control and independence, and strong family interactions." Burke, et al (1997) report that "by coordinating inpatient and outpatient service, short stay observation following breast cancer surgery can be accomplished in a safe environment that patients perceive to be satisfactory and of high quality."

Not all literature, of course, supports the move to outpatient and short lengths of stays. However, no scientific research was brought to the department's attention documenting the prevalence of problems or their impact on outcomes. Reports based on anecdotal sources are included in D. below. The fact that information is "anecdotal" does not, of course, disprove its validity. However, the statutory criteria for sunrise reviews place substantial emphasis on scientifically controlled studies, where available.

C. Professional Guidelines

A number of health care, professional and trade associations have issues recommendations or guidelines relevant to SB 5297, including the following:

American Cancer Society: "treatment decisions for women with breast cancer should be made by physicians in consultation with the patient based on what is medically appropriate. As long as the physician determines that there are no complications following surgery, there is sufficient support in the home, and it is the desire of the patient to be released, then outpatient surgery is appropriate. It is the position of the ACS that the quality of care is of utmost importance when lives of cancer patients are at stake

New Jersey HMO Association: "Health plans should not require outpatient care for removal of a breast...As in all issues the medical treatment, a physician's decision should be based on the best available scientific information and the unique characteristics of each patient."

American Association of Health Plans: Among member plans, "the standard practice is for physicians and their patients to determine the best care following mastectomy, including whether to stay in the hospital or return more quickly to their homes and families. Because of the importance and sensitivity of the issue, AAHP adopted the policy that says: Decisions about a hospital stay following mastectomy should be made by a woman's physician in consultation with the patient herself."

Medicare: the Federal Health and Human Services Department announced several steps in Feburary 1997 "to ensure that Medicare beneficiares are protected from any requirements by health plans that would place time limits on hospital stays for mastectomies." Health Care Financing Administration Administrator Bruce C. Vladeck said that "Medicare patients, who are generally older and may lack social support, may be put at increased risk by having this surgery performed on an outpatient basis, or with insufficient hospital length of stay."

D. Other Published Material on Mastectomy

Shocking cases of HMOs refusing inpatient stays for complicated surgeries on high-risk patients can "make even the most fervent believer in outpatient surgeries skeptical." In one case reported in a July 1997 article in *Good Housekeeping*, the HMO "seemed to have focused on the only parts of [the patient's] condition that its guidebooks showed could be treated with same day surgery....It was clear that the HMO was making a ruling from a standardized list that read 'endometriosis equals same-day surgery,' without factoring in anything else." (Goodwin, 1997)

Similar statements can be found in other sources. However, as noted previously, no scientific research was brought to the department's attention documenting the prevalence of such abuses or their impact on outcomes. Additional examples of the stories follow.

"Many women are sent home with drains coming out of their chest wall. If they're released too soon -- before their pain is controlled, before they understand how to care for the wound, or before they're psychologically prepared -- it can be an extremely jarring experience. It can also raise their risk of infection." Kim Calder of the National Alliance of Breast Cancer Organizations continues in response to a proposed law in Congress

mandating a minimum 48 hour LOS: "This law won't force anyone to stay in the hospital. But it will help ensure that their discharge is a medical decision, not an economic one. And we just can't count on the industry to police itself." "It is not always possible to tell who will need further treatment after surgery, and one-third to half of mastectomy patients do require treatment that can be problematic if the patient is already home," according to Dr. Andrew Salner, director of Hartford Hospital's cancer program. (Reuters, 8/9/96)

Dr. Nina Horowitz, a cancer surgeon at Yale-New Haven hospital, was quoted in the Wall Street Journal (November 1996) as saying that outpatient mastectomies were ill- advised and inappropriate in most cases. Blood clots associated with drainage tubes used for the procedure must be caught early or the wound will not heal properly, according to Dr. Horowitz.

# APPENDIX M

# ANALYSIS OF DOH DATA: DETAILED

## Detailed Analysis of Department of Health Data

Data are reported in Appendices H, I, J and K

The department maintains a hospital discharge data set (CHARS) that captures information on inpatient hospitalizations, including reason for hospitalization, procedures and length of stay (LOS). From this data set, the department developed information on changes in LOS for mastectomies and other procedures in the 1990s. The department also maintains the Washington State Cancer Registry, (WSCR) which provides information about the type of cancer and treatment for each patient. This data set provided information on overall incidence of breast cancer from 1992-1995. Combining information from WSCR and CHARS allowed the department to develop estimates of the proportion of mastectomies conducted on an outpatient basis.

In Washington state, the number of new cases of diagnosed breast cancer has increased from approximately 3800 in 1992 to 4200 in 1995. In 1995, 46% of new cases were in women ages 65 years and older. In the same year, 46% of all in-patient mastectomy surgeries in Washington state were on patients age 65 or older.

In Washington state, the overall LOS for all types of inpatient surgeries reported declined from 5.9 days in 1990 to 4.7 days in 1996. In comparison to other states, using information supplied by the hospital association, Washington has the second smallest average LOS for all surgeries, with Utah having a slightly lower average. The longest average LOS are in North Dakota (11.42 days), Montana (10.43) and South Dakota (10.08). The nationwide total average has declined from 7.20 days in 1990 to an average LOS for all surgeries of 6.74 days in 1994.

For mastectomies, (not including lumpectomies) the average LOS decreased from 2.7 days to 2.0 days from 1990 to 1996. This decline in LOS parallels declines in LOS for other types of surgery. For example, for Cesarean section surgeries, the decline was from 4.2 days in 1990 to 3.5 days in 1996. Normal vaginal deliveries saw a decline from 2.6 days in 1990 to 1.9 days in 1994. Diabetes-related toe amputations saw a change in average LOS from 10.7 days in 1990 to 8.7 days in 1995. Diabetes-related amputations in total changed from 12.93 days average LOS to 8.7 days for the same period.

The decline in LOS is also consistent with declines in other states. In New Jersey, data show that the percentage of "same day" modified radical mastectomies went from 0.3% in 1992 to 1.8% in 1995. (Data provided by State of New Jersey DOH). Connecticut reports that LOS for mastectomies fell 42% from 1991 to 1996, to 3.98 days. (Data provided by Connecticut Office of Health Care Access).

In 1996, Washington HMO patients had an average LOS of 1.8 days, other non-government insurance clients had 1.9 days, and Medicare patients had 2.0 days. HMOs had 51% of patients with a LOS of less than 2 days; other non-government insurance had 44% of patients with LOS of less than 2 days; and Medicare had 40% in that category. Comparisons by payer are available for New Jersey and

Connecticut. New Jersey HMO patients had a higher percentage (8.2%) of same day mastectomies than all payers (4%). In Connecticut, Medicare and Medicaid had the highest average LOS, while HMOs, Blue Cross and Commercial Insurance categories had nearly the same at the low end of reported LOS.

In Washington state, the number of inpatient procedures has fallen, with breast cancer cases diagnosed being relatively steady, suggesting an increase in outpatient surgeries. Estimates of proportion of inpatient surgeries were developed by combining CHARS and WSCR data supports this conclusion. The department estimates that 60% of breast cancer surgeries were performed on an inpatient basis in 1992. For 1995, the estimate for the percent of inpatient surgeries for mastectomy had dropped to about 38%. The largest proportion of outpatient surgeries (over 98% in 1995) were for lumpectomies in women diagnosed with "in situ" breast cancer (i.e., localized in a very small area). Women having mastectomies for regional disease had the largest proportion of inpatient surgeries (67% in 1995). Except for distant stage lumpectomies, the decline was apparent for all stages of diagnosis and for women undergoing mastectomy and lumpectomy.

Connecticut reports a similar trend to outpatient surgery. That state reported that same day surgery mastectomies reported by acute care hospitals rose from 53 in 1991 (compared with 1551 discharges) to 97 in 1996 (compared to 1159 discharges). (Connecticut Office of Health care Access, June 1997)

Hospital readmission data for 1995 shows that of all patients admitted for mastectomy procedures (lumpectomy excluded), 3% were readmitted within 7 days and 5% were readmitted within 14 days. It is not known whether these readmissions were for complications of the mastectomy surgery, The percentage of readmissions remains fairly constant from 1990 to 1996, despite a decrease in average LOS of 25%, and an increase in the percentage of patients staying less than 2 days from 11% to 44%. This is also fairly constant across age groups and by type of payer.

# APPENDIX N

# TESTIMONY: DETAILED

## *Public Testimony*

*(Note: Information is paraphrased or quoted from written or oral testimony provided at the September 9th public meeting, the December 8th public hearing or prior to the written comment period closing on December 18th.)*

Dr. Alison Longley: This does not seem to be appropriate under the mandated benefits sunrise review because there is no specific mandate for length of stay. Having said that, the bill does seem to go in the right direction. The emotional health of a patient is increased when they have control over their medical treatment. The patient and physician should decide the appropriate length of stay.

The importance of control over one's actions, body and life has been well recognized for a very long time; it is the basis for our democracy and our recognized rights. It was only in recent years, however, that scientific studies of the effect of lack of control in their medical care have been done. These studies clearly demonstrate that the emotional health of patients who have control over their medical treatment is far better than that of patients who have that control taken from them. Breast cancer patients who choose their surgery, for example, are much less likely to become depressed afterward than those who are not given a choice. The intent of SB 5297 is to "recognize patient preference and the clinical sovereignty of providers," and this concept merits support.

As a breast cancer survivor, I can say from personal experience that for a woman who is losing a breast to save her life, the last thing she needs is to be told that she has no choice but to leave the hospital the same day.

Our task force, put together to work on this review, conducted an opportunistic survey, primarily among Team Survivors Northwest. Seventy-three responses from mastectomy patients were received. About one-half said they and their physicians had primary responsibility for length of stay decisions. About one-half felt their physicians were influenced by the insurance carrier. Some reported being forced to leave with vomiting or fever. One-third reported complication, and some of those felt the complications could have been avoided by a longer length of stay.

It would be useful to distribute information to patients, providers and insurance carriers about the way to safely have shorter length of stays.

Dr. Cathleen Carr: Our task force's provider survey has been delayed. A surgeons' organization will be sending out our survey. We will not reveal

that organization to you at this time. We will not be providing you with written information about our surveys or the results.

We were able to get a small opportunistic sample at a continuing education meeting in Seattle. The four surgeons who responded indicated that the need for pain medication, continuing fever and vomiting were the types of complications patients were having upon discharge. One of the four felt compelled to discharge early by their insurance company.

There is a lot of fear involved with cancer, and this fear contributes to apprehension about treatment and possible interference by health plans in that treatment.

*Bill Moore (Blue Cross of Washington and Alaska?*

Current practice by physicians and health plans conforms to what is in this bill. Why do we need to put it into statute, then?

*PacificCare of Washington*

PacifiCare of Washington does not have clinical guidelines related to breast cancer. The surgery must be prior authorized and the surgeon must be qualified and credentialed. PacifiCare expects the surgeon, medical group and Primary Care Provider to work with the woman to select that woman's most appropriate procedure and pre and post-operative care, both inpatient and outpatient. There are Utilization Management guidelines which require providers to do concurrent review on inpatient stays, and we monitor global average length of stay to ensure there is not over or under utilization occurring.

The legislation proposes that the attending physician along with the patient make decision on the length of an inpatient stay. As mentioned in the public hearing, not all surgeries require an inpatient stay. There are often women who spend the night who have been in the hospital less than 24 hours; these are considered outpatient stays. Additionally,, the proposed length of stay discussions are already occurring between providers and patients. PacifiCare does not have any explicit language that addresses discharging timing in the provider contracts - early discharge or otherwise.

PacifiCare has been able to access some data regarding average length of stay. The data is separated between our Active Commercial population and our Retired Medicare population. The data generated is based on PacifiCare of Washington experience form August 1996 to April 1997.

| Commercial Population | | | | |
|---|---|---|---|---|
| Procedure | Explanation | Admits | Avg. LOS | % Readmit |
| 85.41 | Unilateral simple mastectomy | 1 | 1.0 | 0% |
| 85.43 | Unilateral extended simple mast. | 10 | 2.0 | 0% |

| Medicare Population | | | | |
|---|---|---|---|---|
| DRG 257 | Total Mastectomy w/complications | 12 | 1.4 | 0% |
| DRG 258 | Total Mastect. w/o complications | 9 | 1.4 | 0% |
| DRG 260 | Subtotal Mast. w/o complications | 6 | 1.0 | 0% |

*Dr. J. Kyle Bryan, Pacific Medical Clinics*

SB 5297 gives patient preference and provider's sovereignty over the length of stay following the mastectomy. I support this position wholeheartedly and request your support as well.

As a medical oncologist, I have the unique opportunity to observe patients in both the preoperative and postoperative setting. I am there not only as a provider of medical care, but also as a resource for patient information. Almost uniformly, these women express to me their concerns and fears regarding the seriousness of this diagnosis, the complexity of the treatment, and the possibility of death that lurks over them. In order to manage these fears and improve the overall treatment process, I encourage patients to take the initiative and become actively involved in all stages of their treatment.

I have found that a patient who understands her disease and can be involved in the decision making is more likely to have a good outcome and less disruption to her life. One of the many decisions that a woman must make is with regard to the best form of surgery, usually either a modified radical mastectomy or a segmental mastectomy. Both of these procedures are commonly accompanied by a dissection to remove the lymph nodes from the axilla (the area beneath the arm). Regardless of the type of mastectomy, the lymph node dissection is an extremely debilitating procedure, but crucial in providing the information needed to recommend postoperative chemotherapy and/or radiation.

After the surgery the arm is quite painful and practically useless for all but the simplest tasks for some time. A woman who has undergone this procedure has vital need for appropriate assistance in her care. Sadly, all too many of my patients do not have the available family members to assist them and must rely on the medical community aid, or go without at risk to their health.

Breast cancer patients have revealed in a recent study their fear regarding the limiting of length of hospital stay after mastectomy, and the possibility that ambulatory mastectomies may be imposed by managed care guidelines. These fears are common when one has been diagnosed with cancer and is concerned about the quality of care one may receive. Unfortunately, there have been a tendency within the insurance and managed care industry in the direction of shorter inpatient stays without also providing the necessary outpatient care. These groups have chosen to extrapolate the findings of a few studies on patients who received outpatient mastectomy under ideal conditions to the general mastectomy patient. This type of across-the-board decision making is always inadvisable, particularly when dealing with as diverse a group of patients as those with cancer.

Most patients have no desire to be in the hospital any longer than absolutely necessary, but at the same time there is the need to have the ability to stay in as long as their practitioner deems appropriate. It is both good public policy and good medicine to acknowledge these patients' fears and attempt to address them by enacting legislation such as SB 5297.

PARTICIPANT LIST: The following participated in one or more ways during the review.

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# APPENDIX O

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